# Washington State Labor & Industries Workers' Compensation at Hanford

***Hanford Site Points of Contact for WRPS employees:***

**Teena Taber**, WRPS, Workers' Compensation Representative
509-372-3639

**Patty Hicks**, Penser, Third Party Administrator
509-420-7290

**Juli Yamauchi**, DOE, Program Manager for Site Workers' Compensation
509-438-3383

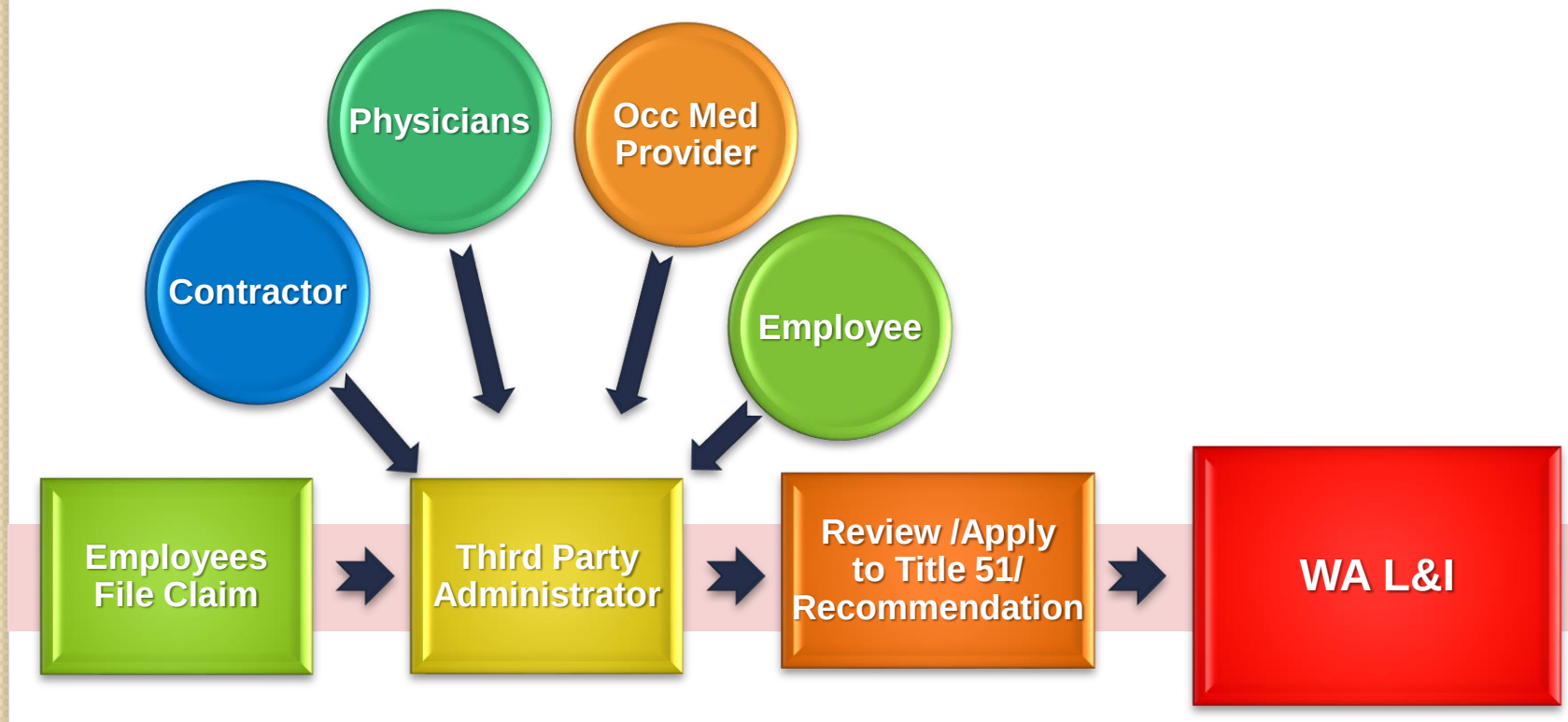
**Jan. 2017**

# Background/Facts

- DOE is Self-Insured under Washington State Labor and Industries (L&I) and provides workers' compensation coverage under this Self-Insurance to our prime contractors. As a Washington State self-insurer, DOE is required to follow all Washington State rules and regulations that govern the L&I workers' compensation process.
- The self-insurance section at L&I provides oversight of DOE's self-insurance program, and performs compliance audits.
- Workers covered by self-insurance are covered under the same industrial insurance laws as workers who are covered by state fund insurance.

# How Claims Are Administered

- Penser administers claims filed by Hanford workers per Title 51 of the Revised Code of Washington
- Only L&I has the authority to approve or deny claims (Not Penser, DOE, or contractors)



# Compensability

- For both an injury and occupational disease claims, a medical condition must be diagnosed and the medical condition diagnosed must be related to the incident and/or job duties on a “more probable than not basis”
- It is not sufficient that a physician indicate “possibly” or “may” be the cause

# Workers Role

- Report the injury to your employer
- Request a Self Insurer Accident Report (SIF2) from your Worker’s Compensation Representative (WCR)
- See a doctor of your choice
- The doctor will complete the Physician’s  Initial Report (PIR) form
- The doctor mails the completed PIR to the Third Party Administrator (TPA)

# Workers Responsibility

- You need to tell the doctor if you feel the injury or disease is work related
- Respond timely to requests for information from the WCR or Penser:
  - prior medical
  - attending physician contact information
  - correct personal contact information
  - work history
- Communication with your claims examiner will help you understand the process

# Benefits Covered

- Medical treatment/bills
- Wage compensation
- Vocational services
- Permanent partial disability

# Ten things you need to know about your claim from the Office of the Ombudsman for Injured Workers of Self-Insured Businesses

- You cannot waive your rights under Washington industrial insurance law.
- You have the right to choose your attending physician.
- Your cannot be discriminated against for filing a claim.
- If you are unable to work as a result of your injury or occupational disease, you will be paid a portion of your wages.
- A protest or appeal to an order must be made in writing. Follow the instructions on the order.
- You are entitled to a copy of your claim file from your employer or your employer's third party administrator (TPA).
- Keep copies of all your claim related information.
- Attend your medical appointments and follow your prescribed treatment plan.
- Keep in contact with your employer.
- Do not ignore work-related medical bills sent to you. Contact your employer or the TPA. Heath-care providers should bill your employer or TPA directly for work-related treatment.

# Frequently Asked Questions from the Office of the Ombudsman for Injured Workers of Self-Insured Businesses

**My employer is self-insured for workers' compensation. Am I entitled to the same coverage as an employee who works for a state fund employer?**

*Yes. All Washington workers are covered under the same industrial insurance law.*

**Who manages my workers' compensation claim?**

*Your employer may self administer industrial insurance claims, or contract with a third party administrator to manage the claims.*

**How do I obtain a copy of my claim file?**

*Send a written request to your employer or third-party administrator (TPA). You are entitled to one copy of your file and any updates. You may be charged for duplicate copies.*

**How is time-loss compensation calculated?**

*Time-loss rates can vary from 60 to 75 percent of your total wages up to a statutory limit. Your time-loss compensation rate is calculated based upon your total wages at the time of injury, your marital status and number of dependents. The self-insured employer or third-party administrator (TPA) must provide a copy of forms SIF-5 and SIF-5A to you on the date of the first time-loss payment. These forms contain the information used to calculate your benefits. Review them carefully.*

# Frequently Asked Questions from the Office of the Ombudsman for Injured Workers of Self-Insured Businesses (continued)

**Am I allowed to choose my health care provider?**

*Yes. Under Washington state industrial insurance law, you have the right to select your health care provider from within the Medical Provider Network. The provider you select must be qualified to treat your condition.*

**I was scheduled for an independent medical exam (IME). Do I have to attend?**

*Yes. The law allows the department or self insurer to arrange for an IME to resolve medical issues. (RCW 51.36.070). The exam should be scheduled at a location reasonably convenient for you. You will be reimbursed for your time and travel expenses to attend the examination. (RCW 51.32.110)*

**I received a bill from my health care provider for injury-related treatment. What do I do?**

*Contact your employer or third-party administrator immediately. All injury related medical bills should be sent directly to them for payment*.

# Other Resources For Information:

Juli Yamauchi

Program Manger for Hanford Site Workers' Compensation

http://www.hanford.gov/AboutUS/Hanfordsitewideprograms/hanfordworkerscompensation

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Self insurance section of the Washington State
Department of Labor & Industries
Phone: 360-92-6901

Website: http://www.lni.wa.gov/Main/WorkerTopics.asp

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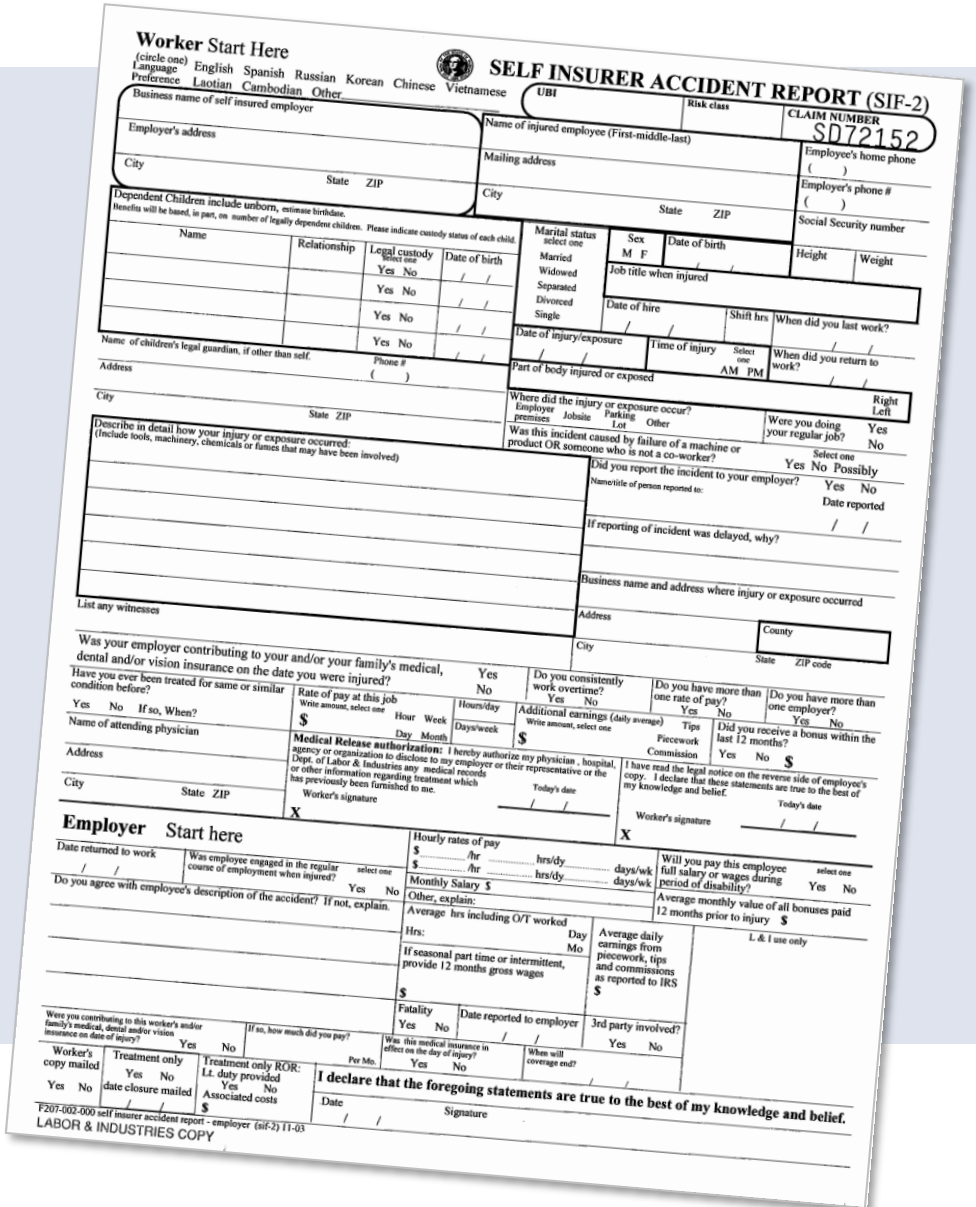
Department of Labor & Industries/Office of the Self Insured Ombudsman -
"The Office of the Ombuds advocates for the rights of injured workers of self-insured employers by providing information, investigating complaints and taking action to ensure the worker receives the appropriate benefits under Washington state industrial insurance law."
Phone: 1-888-317-0493

Website: Ombudsman.Selfinsured.wa.gov

To locate a provider: findadoc@lni.wa.gov

# SIF2 – Self Insured Accident Report



**Worker** Start Here

SELF INSURER ACCIDENT REPORT (SIF-2)

(circle one) Language Preference: English Spanish Russian Korean Chinese Vietnamese Laotian Cambodian Other

UBI | Risk class | CLAIM NUMBER SD72152

Business name of self insured employer

Employer's address

City State ZIP

Name of injured employee (First-middle-last)

Mailing address

City State ZIP

Employee's home phone ( )

Employer's phone # ( )

Social Security number

Dependent Children include unborn, estimate birthdate.
Benefits will be based, in part, on number of legally dependent children. Please indicate custody status of each child.

| Name | Relationship | Legal custody (Select one) | Date of birth |
|---|---|---|---|
| | | Yes No | / / |
| | | Yes No | / / |
| | | Yes No | / / |

Marital status (select one): Married, Widowed, Separated, Divorced, Single

Sex: M F

Date of birth / /

Height Weight

Job title when injured

Date of hire / /

Shift hrs

When did you last work? / /

Name of children's legal guardian, if other than self. Phone # ( )

Address

City State ZIP

Date of injury/exposure / /

Time of injury (Select one) AM PM

When did you return to work? / /

Part of body injured or exposed (Right Left)

Where did the injury or exposure occur? (Employer premises, Jobsite, Parking Lot, Other)

Were you doing your regular job? Yes No

Was this incident caused by failure of a machine or product OR someone who is not a co-worker? (Select one) Yes No Possibly

Describe in detail how your injury or exposure occurred: (Include tools, machinery, chemicals or fumes that may have been involved)

Did you report the incident to your employer? Yes No

Name/title of person reported to:

Date reported / /

If reporting of incident was delayed, why?

List any witnesses

Business name and address where injury or exposure occurred

Address

City State ZIP code

County

Was your employer contributing to your and/or your family's medical, dental and/or vision insurance on the date you were injured? Yes No

Do you consistently work overtime? Yes No

Do you have more than one rate of pay? Yes No

Do you have more than one employer? Yes No

Have you ever been treated for same or similar condition before? Yes No If so, When?

Rate of pay at this job (Write amount, select one) $ Hour Week Day Month

Hours/day

Days/week

Additional earnings (daily average) (Write amount, select one) $ Tips Piecework Commission

Did you receive a bonus within the last 12 months? Yes No $

Name of attending physician

Address

City State ZIP

**Medical Release authorization:** I hereby authorize my physician , hospital, agency or organization to disclose to my employer or their representative or the Dept. of Labor & Industries any medical records or other information regarding treatment which has previously been furnished to me.

Worker's signature X

Today's date / /

I have read the legal notice on the reverse side of employee's copy. I declare that these statements are true to the best of my knowledge and belief.

Worker's signature X

Today's date / /

**Employer** Start here

Date returned to work / /

Was employee engaged in the regular course of employment when injured? (select one) Yes No

Hourly rates of pay
$ /hr hrs/dy days/wk
$ /hr hrs/dy days/wk

Monthly Salary $

Other, explain:

Will you pay this employee full salary or wages during period of disability? (select one) Yes No

Average monthly value of all bonuses paid 12 months prior to injury $

L. & I. use only

Do you agree with employee's description of the accident? If not, explain.

Average hrs including O/T worked
Hrs: Day Mo

If seasonal part time or intermittent, provide 12 months gross wages
$

Average daily earnings from piecework, tips and commissions as reported to IRS
$

Were you contributing to this worker's and/or family's medical, dental and/or vision insurance on date of injury? Yes No

If so, how much did you pay? Per Mo.

Was this medical insurance in effect on the day of injury? Yes No

When will coverage end? / /

Fatality Yes No

Date reported to employer / /

3rd party involved? Yes No

Worker's copy mailed Yes No

Treatment only Yes No date closure mailed / /

Treatment only ROR: Lt. duty provided Yes No Associated costs $

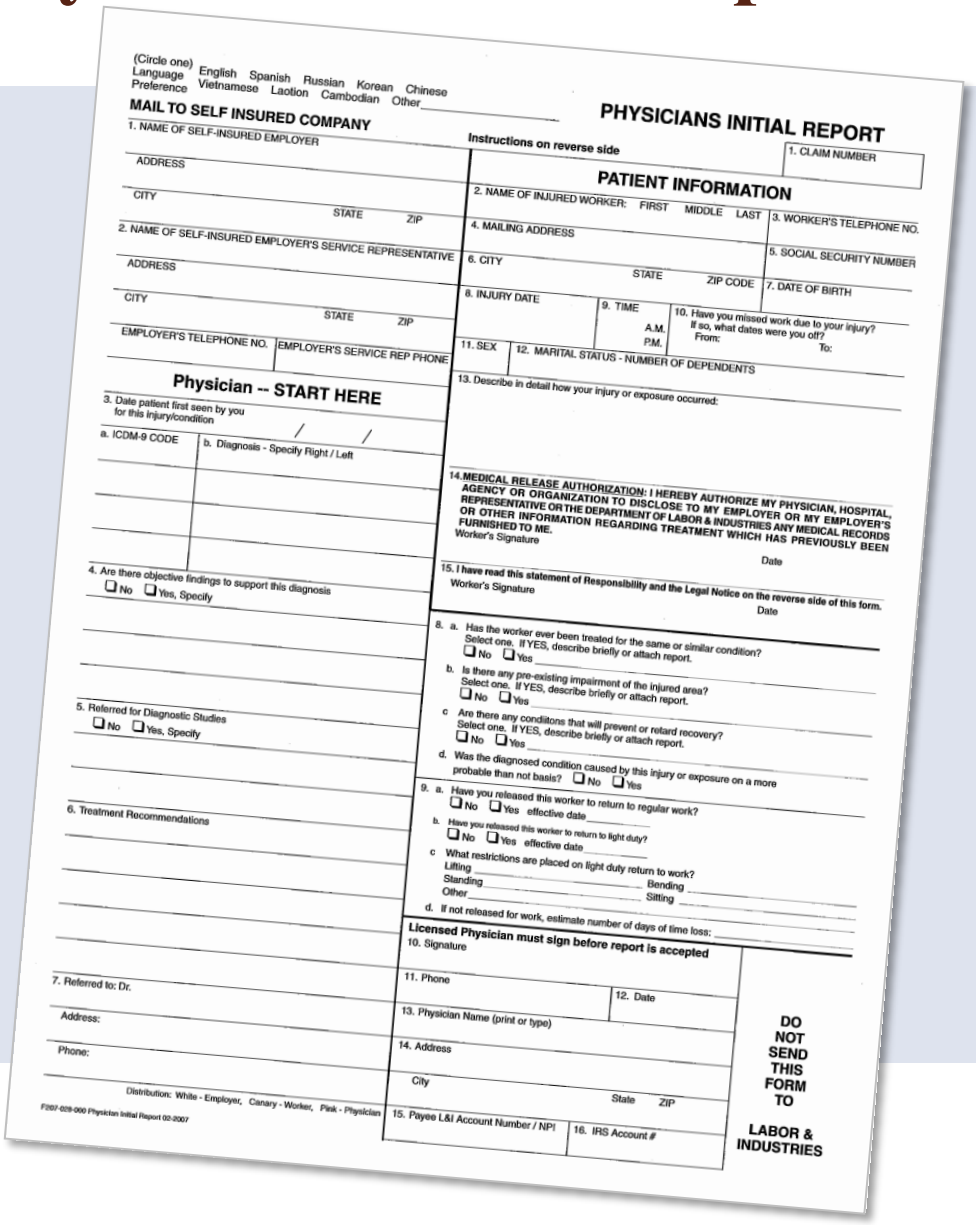
**I declare that the foregoing statements are true to the best of my knowledge and belief.**

Date / / Signature

F207-002-000 self insurer accident report - employer (sif-2) 11-03

LABOR & INDUSTRIES COPY

# PIR – Physician's Initial Report



(Circle one) Language Preference: English Spanish Russian Korean Chinese Vietnamese Laotion Cambodian Other

**MAIL TO SELF INSURED COMPANY**

1. NAME OF SELF-INSURED EMPLOYER
ADDRESS
CITY STATE ZIP
2. NAME OF SELF-INSURED EMPLOYER'S SERVICE REPRESENTATIVE
ADDRESS
CITY STATE ZIP
EMPLOYER'S TELEPHONE NO. EMPLOYER'S SERVICE REP PHONE

**Physician -- START HERE**

3. Date patient first seen by you for this injury/condition / /
a. ICDM-9 CODE b. Diagnosis - Specify Right / Left
4. Are there objective findings to support this diagnosis ☐ No ☐ Yes, Specify
5. Referred for Diagnostic Studies ☐ No ☐ Yes, Specify
6. Treatment Recommendations
7. Referred to: Dr.
Address:
Phone:

Distribution: White - Employer, Canary - Worker, Pink - Physician

F207-028-000 Physician Initial Report 02-2007

**PHYSICIANS INITIAL REPORT**

Instructions on reverse side

1. CLAIM NUMBER

**PATIENT INFORMATION**

2. NAME OF INJURED WORKER: FIRST MIDDLE LAST
3. WORKER'S TELEPHONE NO.
4. MAILING ADDRESS
5. SOCIAL SECURITY NUMBER
6. CITY STATE ZIP CODE
7. DATE OF BIRTH
8. INJURY DATE
9. TIME A.M. P.M.
10. Have you missed work due to your injury? If so, what dates were you off? From: To:
11. SEX
12. MARITAL STATUS - NUMBER OF DEPENDENTS
13. Describe in detail how your injury or exposure occurred:

14. **MEDICAL RELEASE AUTHORIZATION:** I HEREBY AUTHORIZE MY PHYSICIAN, HOSPITAL, AGENCY OR ORGANIZATION TO DISCLOSE TO MY EMPLOYER OR MY EMPLOYER'S REPRESENTATIVE OR THE DEPARTMENT OF LABOR & INDUSTRIES ANY MEDICAL RECORDS OR OTHER INFORMATION REGARDING TREATMENT WHICH HAS PREVIOUSLY BEEN FURNISHED TO ME.
Worker's Signature Date

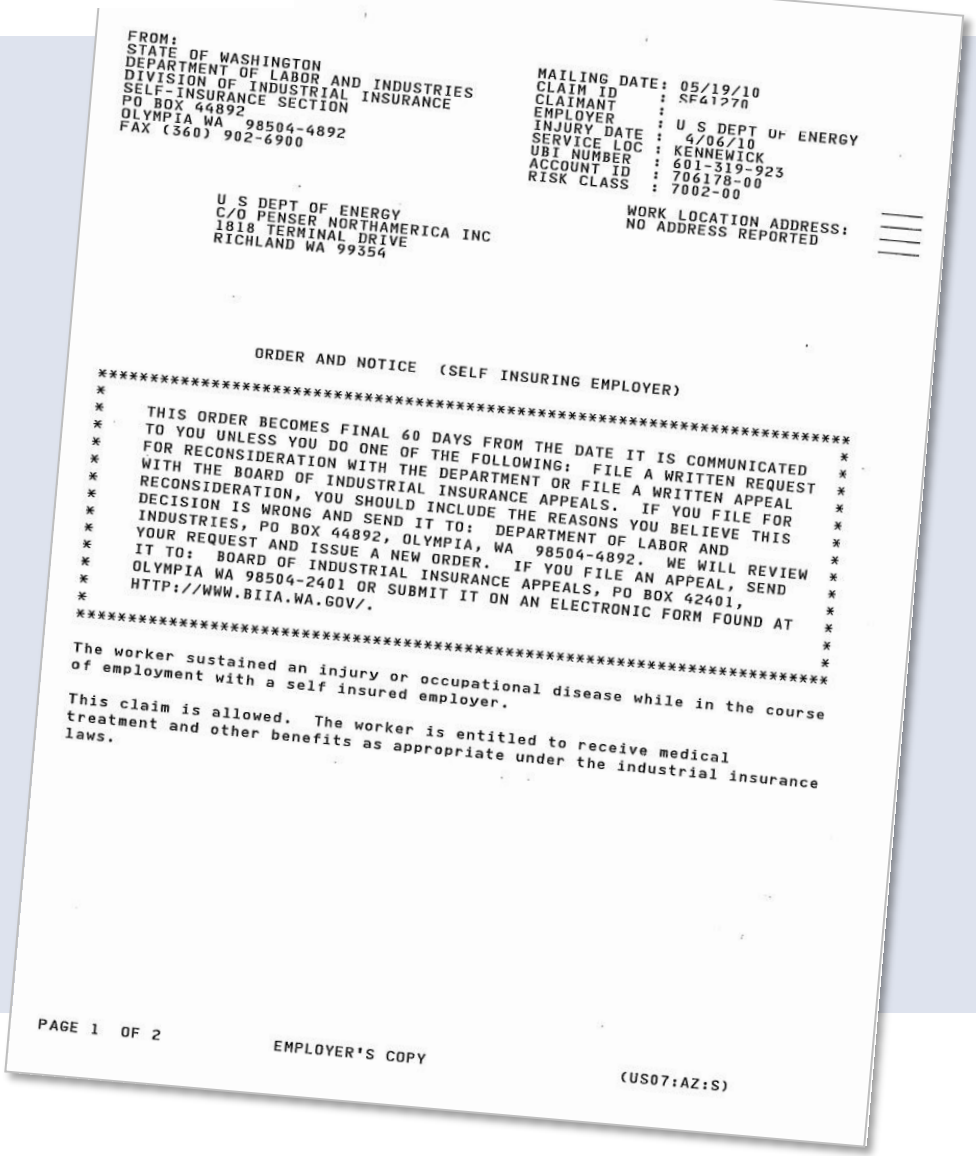
15. **I have read this statement of Responsibility and the Legal Notice on the reverse side of this form.**
Worker's Signature Date

8. a. Has the worker ever been treated for the same or similar condition? Select one. If YES, describe briefly or attach report. ☐ No ☐ Yes
b. Is there any pre-existing impairment of the injured area? Select one. If YES, describe briefly or attach report. ☐ No ☐ Yes
c Are there any conditions that will prevent or retard recovery? Select one. If YES, describe briefly or attach report. ☐ No ☐ Yes
d. Was the diagnosed condition caused by this injury or exposure on a more probable than not basis? ☐ No ☐ Yes
9. a. Have you released this worker to return to regular work? ☐ No ☐ Yes effective date
b. Have you released this worker to return to light duty? ☐ No ☐ Yes effective date
c What restrictions are placed on light duty return to work?
Lifting Bending
Standing Sitting
Other
d. If not released for work, estimate number of days of time loss:

**Licensed Physician must sign before report is accepted**
10. Signature
11. Phone
12. Date
13. Physician Name (print or type)
14. Address
City State ZIP
15. Payee L&I Account Number / NPI
16. IRS Account #

**DO NOT SEND THIS FORM TO LABOR & INDUSTRIES**

# Department of Labor & Industries Order & Notice



FROM:
STATE OF WASHINGTON
DEPARTMENT OF LABOR AND INDUSTRIES
DIVISION OF INDUSTRIAL INSURANCE
SELF-INSURANCE SECTION
PO BOX 44892
OLYMPIA WA 98504-4892
FAX (360) 902-6900

MAILING DATE: 05/19/10
CLAIM ID : SF41270
CLAIMANT :
EMPLOYER : U S DEPT OF ENERGY
INJURY DATE : 4/06/10
SERVICE LOC : KENNEWICK
UBI NUMBER : 601-319-923
ACCOUNT ID : 706178-00
RISK CLASS : 7002-00

U S DEPT OF ENERGY
C/O PENSER NORTHAMERICA INC
1818 TERMINAL DRIVE
RICHLAND WA 99354

WORK LOCATION ADDRESS:
NO ADDRESS REPORTED

ORDER AND NOTICE (SELF INSURING EMPLOYER)

THIS ORDER BECOMES FINAL 60 DAYS FROM THE DATE IT IS COMMUNICATED TO YOU UNLESS YOU DO ONE OF THE FOLLOWING: FILE A WRITTEN REQUEST FOR RECONSIDERATION WITH THE DEPARTMENT OR FILE A WRITTEN APPEAL WITH THE BOARD OF INDUSTRIAL INSURANCE APPEALS. IF YOU FILE FOR RECONSIDERATION, YOU SHOULD INCLUDE THE REASONS YOU BELIEVE THIS DECISION IS WRONG AND SEND IT TO: DEPARTMENT OF LABOR AND INDUSTRIES, PO BOX 44892, OLYMPIA, WA 98504-4892. WE WILL REVIEW YOUR REQUEST AND ISSUE A NEW ORDER. IF YOU FILE AN APPEAL, SEND IT TO: BOARD OF INDUSTRIAL INSURANCE APPEALS, PO BOX 42401, OLYMPIA WA 98504-2401 OR SUBMIT IT ON AN ELECTRONIC FORM FOUND AT HTTP://WWW.BIIA.WA.GOV/.

The worker sustained an injury or occupational disease while in the course of employment with a self insured employer.

This claim is allowed. The worker is entitled to receive medical treatment and other benefits as appropriate under the industrial insurance laws.

PAGE 1 OF 2 EMPLOYER'S COPY (US07:AZ:S)